

BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

**MICHAEL OGDEN, M.D.**

License No. 11188  
For the Practice of Allopathic Medicine  
In the State of Arizona.

Case No. MD-02-0561

**CONSENT AGREEMENT FOR  
PROBATION**

**CONSENT AGREEMENT**

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Michael Ogden, M.D. ("Respondent"), the parties agreed to the following disposition of this matter.

1. Respondent acknowledges that he has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter and has done so or chooses not to do so.

2. Respondent understands that by entering into this Consent Agreement, he voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Order.

3. Respondent acknowledges and understands that this Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or

1 any other state or federal court.

2 5. Respondent acknowledges and agrees that, although the Consent  
3 Agreement has not yet been accepted by the Board and issued by the Executive Director,  
4 upon signing this agreement, and returning this document (or a copy thereof) to the  
5 Board's Executive Director, Respondent may not revoke the acceptance of the Consent  
6 Agreement. Respondent may not make any modifications to the document. Any  
7 modifications to this original document are ineffective and void unless mutually approved  
8 by the parties.

9 6. Respondent further understands that this Consent Agreement, once  
10 approved and signed, is a public record that may be publicly disseminated as a formal  
11 action of the Board and will be reported to the National Practitioner Data Bank and to the  
12 Arizona Medical Board's website.

13 7. If any part of the Consent Agreement is later declared void or otherwise  
14 unenforceable, the remainder of the Consent Agreement in its entirety shall remain in  
15 force and effect.

16  
17  
18 Michael Ogden M.D.  
19 MICHAEL OGDEN, M.D.

DATED: 11.26.2003

**FINDINGS OF FACT**

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 11188 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-02-0561 after receiving a complaint regarding Respondent's care and treatment of a 7 year-old male patient ("D.K").

4. On April 23, 2001, D.K. first presented to Respondent, a staff psychiatrist at Touchstone Community, Inc. for a 15-minute appointment. Respondent noted that D.K.'s behavior was consistent with the previously diagnosed attention deficit disorder ("ADD") and adjustment deficit and hyperactivity disorder ("ADHD"). Respondent indicated that D.K. displayed oppositional and defiant behavior toward his mother. Respondent continued D.K. on Depakote 250 mg bid and methylphenidate 10 mg to be taken at 7:00 a.m., 10:00 a.m., 2:00 p.m., and 5 mg at 4:00 p.m.

5. On May 7, 2001, D.K. failed to appear for his scheduled appointment with Respondent.

6. On July 2, 2001, D.K.'s mother reported to Respondent that he seemed to be in control of his temper. The medication remained unchanged.

7. At a July 23, 2001, office visit D.K.'s mother notified Respondent that D.K. was "wild" in the mornings. Respondent added a small dose of Seroquel 25 mg, increased the dosage of Depakote to 250 mg tid, and continued with methylphenidate. Respondent stated that he discussed the medications with D.K.'s mother and she suggested additional testing for D.K. Respondent indicated that he suggested she arrange neuropsychologic testing through her primary care physician. Respondent noted that D.K. and his two year-

1 old brother were out of control in the examining room. Respondent stated that he did not  
2 see D.K. again until September 2001.

3 8. On September 13, 2001, D.K. and his mother presented to Respondent.  
4 D.K.'s mother indicated that she discontinued the Seroquel. Respondent indicated that he  
5 observed D.K.'s mother interacting with D.K. and his brother and could not control their  
6 behavior in the examining room. Respondent prescribed 0.1 mg clonidine four times a day  
7 to D.K.

8 9. On October 11, 2001, D.K. presented to Respondent for a follow-up visit.  
9 Respondent noted that D.K.'s behavior was improved, he had better concentration and  
10 appeared calmer. Respondent stated that D.K. was not hyperactive during this office visit.  
11 D.K.'s mother requested discontinuing the clonidine because she did not think it helped  
12 D.K. and that it actually made him more aggressive. Subsequently, D.K.'s mother  
13 canceled a November scheduled office visit at the last minute.

14 10. In December 2001, D.K.'s mother reported to Respondent that D.K. was  
15 doing much better in a new school.

16 11. In January 2002, D.K.'s mother notified Respondent that she had cut the  
17 methylphenidate to 10 mg three times a day. D.K.'s mother asked about Desmopressin  
18 ("DDAVP") for D.K.'s enuresis and Respondent indicated Value Options, a behavioral  
19 health entity, would not pay for DDAVP. Respondent suggested starting D.K. on  
20 imipramine 10 mg at bedtime.

21 12. On February 14, 2002, Respondent increased D.K.'s methylphenidate to 15  
22 mg to be taken at 7:00 a.m., 11:00 a.m., and 3:00 p.m. Meanwhile, a urologist saw D.K.  
23 and increased his imipramine to 25 mg at bedtime. The urologist reported that D.K.'s  
24 enuresis had improved.

25 13. On May 28, 2002, D.K.'s mother reported to Respondent that D.K. was doing

1 well on his current dosage of medication

2 14. On June 24, 2002, D.K. presented to Respondent for a follow-up visit.  
3 Respondent noted that D.K. was calm, polite and well behaved. D.K.'s mother was  
4 present and stated to Respondent that D.K. would not follow directions and would talk  
5 back to her. Respondent noted that D.K.'s mother again requested referral for a  
6 neuropsychologic evaluation. Respondent stated that he and the Chief Operating Officer  
7 of Touchstone Community ("Mr. G.") discussed this referral with D.K.'s mother.  
8 Subsequently, Mr. G. contacted the Medical Director of southwest Network ("Dr. R.") and  
9 requested permission to refer D.K. for a neuropsychologic evaluation. Dr. R. indicated that  
10 she did not feel a neuropsychologic evaluation was warranted at this time. Subsequently,  
11 D.K.'s mother requested a reduction of D.K.'s medication methylphenidate to 10 mg taken  
12 three times a day.

13 15. On July 22, 2002, D.K. failed to appear for his scheduled appointment with  
14 Respondent.

15 16. Complainant alleged that Respondent only provided psychiatric medication  
16 to D.K. and did not provide any testing or extensive evaluations.

17 17. Respondent admitted that he has not kept up to date on the different types of  
18 ADD and ADHD. Respondent further admitted that he failed to document D.K.'s height  
19 and weight at each visit and did not recognize D.K.'s weight loss there is no discussion of  
20 any weight loss. Respondent stated that sometimes a scale was not available in the  
21 public mental health clinic where D.K. was being treated. Respondent also stated he had  
22 some communication with a psychologist regarding D.K., but it was not documented.

23 18. Respondent indicated that he changed D.K.'s medication according to the  
24 mother's requests and the original child psychiatrist's recommendations. He further stated  
25 that a child psychiatrist is available only 2 hours per week and that he could have insisted

1 that D.K. be seen. Respondent did not make a referral.

2 19. Respondent stated very strongly that his evaluations and record keeping  
3 might be constrained and limited due to the 15-minute time limits allocated for these visits.  
4 Respondent indicated that he has used S.O.A.P. format in the past, but not at the time he  
5 was treating D.K.

6 20. Subsequently, Respondent has made a particular effort to improve his record  
7 keeping. Specifically, he now includes more detail in each case as to the information  
8 provided by the patient (or his/her parent), his observations and findings, his assessment,  
9 and his recommendations in a S.O.A.P. format. Respondent also indicated that he is  
10 working with a behavioral health system to develop a form for recording psychiatric notes  
11 of the medication evaluation visits.

12 21. Respondent is required to maintain adequate records containing, at a  
13 minimum, sufficient information to identify the patient, support the diagnosis, justify the  
14 treatment, accurately document the results, indicate advice and cautionary warnings  
15 provided to the patient and provide sufficient information for another practitioner to assume  
16 continuity of the patient's care at any point in the course of treatment.

17 22. The standard of care during psychiatric diagnosis and treatment of a juvenile  
18 patient required Respondent to perform evaluations for the establishment of the diagnosis  
19 and to review and assess the evaluations performed by other professionals. Also, the  
20 standard of care required Respondent's diagnosis to be complete and substantiated.  
21 Further, the standard of care required Respondent to document his rationale for treatment  
22 and properly monitor and document the patient's response, including consulting with the  
23 patient's on-site therapist or by reviewing school reports. The standard of care also  
24 required Respondent to refer the patient to a specialized child and adolescent psychiatrist  
25 when the standard basic therapy failed within the public health care system and document

1 unsuccessful attempts for referral and to keep up to date on the different types of ADD and  
2 ADHD.

3 23. Respondent failed to meet the accepted standard of care because he failed  
4 during a psychiatric diagnosis and treatment of a juvenile patient to perform evaluations for  
5 the establishment of the diagnosis and review and assess the evaluations performed by  
6 other professionals. Also, Respondent failed to meet the standard of care because his  
7 diagnosis was not complete or substantiated. Further, Respondent failed to meet the  
8 accepted standard of care because he failed to document his rationale for treatment and  
9 failed to properly monitor and document the patient's response, including consulting with  
10 the patient's on-site therapist or by reviewing school reports. Respondent also failed to  
11 refer the patient to a specialized child and adolescent psychiatrist when the standard basic  
12 therapy failed within the public health care system and document unsuccessful attempts  
13 for referral and to keep up to date on the different types of ADD and ADHD.

14 24. D.K. was harmed because he experienced anorexia and weight loss there  
15 are no findings above documenting any anorexia or weight loss during a theoretically  
16 critical period of the brain's growth to its final adult size. D.K. was also harmed because  
17 he spent a year in treatment without any gains and he experienced an increase in his  
18 academic and social morbidity.

### 19 CONCLUSIONS OF LAW

20 1. The Board possesses jurisdiction over the subject matter hereof and over  
21 Respondent.

22 2. The conduct and circumstances described above constitute unprofessional  
23 conduct pursuant to A.R.S. § 32-1401(24)(II) - ("[c]onduct that the board determines is  
24 gross negligence, repeated negligence or negligence resulting in harm to or death of a  
25 patient.")

3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(24)(e) – ("failing or refusing to maintain adequate records on a patient.")

**ORDER**

IT IS HEREBY ORDERED THAT:

1. Respondent is placed on probation for 1 year with the following terms and conditions:

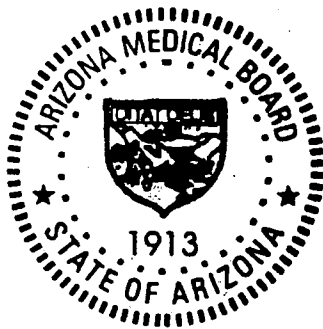
A. Continuing Medical Education (CME)

Respondent shall, within 1 year of the effective date of this Order, obtain 20 hours of Board Staff pre-approved Category I Continuing Medical Education (CME) in current types, modes of evaluation, and treatment of juvenile ADD and ADHD and provide Board Staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for the biennial renewal of medical license.

2. This Order is the final disposition of case number MD-02-0561.

DATED AND EFFECTIVE this 12<sup>th</sup> day of December, 2003.

(SEAL)



ARIZONA MEDICAL BOARD

By Barry A. Cassidy  
BARRY A. CASSIDY, Ph.D., PA-C  
Executive Director

ORIGINAL of the foregoing filed this  
12<sup>th</sup> day of December, 2003 with:

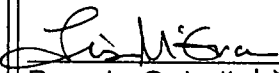
Arizona Medical Board  
9545 E. Doubletree Ranch Road  
Scottsdale, AZ 85258

1 EXECUTED COPY of the foregoing mailed  
2 this 12<sup>m</sup> day of December, 2003 to:

3 J. Mark Ogden  
4 Little Mendelson PC  
5 2425 E. Camelback Road, Suite 900  
6 Phoenix, AZ 85016-4242  
7 Attorney for Michael Ogden, M.D.

8 EXECUTED COPY of the foregoing mailed by  
9 Certified Mail this 12<sup>m</sup> day of December, 2003 to:

10 Michael Ogden, M.D.  
11 1050 E. Southern Avenue, Suite A-1  
12 Tempe, AZ 85282-5437

13   
14 ~~Brenda Gobetti~~ Lisa McGrane  
15 Legal Coordinator  
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